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FISCAL IMPACT STATEMENT

LS 6185 **NOTE PREPARED:** Apr 4, 2005
BILL NUMBER: SB 66 **BILL AMENDED:** Mar 31, 2005

SUBJECT: Hospital Care and Reimbursement under Medicaid and Organ Procurement.

FIRST AUTHOR: Sen. Dillon **BILL STATUS:** 2nd Reading - 2nd House
FIRST SPONSOR: Rep. Becker

FUNDS AFFECTED: X **GENERAL** **IMPACT:** State & Local
X **DEDICATED**
X **FEDERAL**

Summary of Legislation: *Medicaid Managed Care, Lake County:* This bill extends provisions of law until December 31, 2007, that: (1) prohibit the Office of Medicaid Policy and Planning (Office) or the Office's managed care contractor from providing incentives or mandates that direct certain individuals to specified hospitals other than the hospital located in the city where the patient resides unless specified conditions are met; (2) require reimbursement for specified hospitals for services provided if certain conditions are met; and (3) require an inflation adjustment factor to be applied to the reimbursements.

Hospital Care for the Indigent (HCI) Provisions: The bill extends the deadline in which a hospital has to file an application for the hospital care for the indigent program (program) from 30 days to 45 days. It specifies the services or items included as a payable claim in the program. The bill also makes changes to the procedures and requirements to file a claim and determine eligibility in the program. It provides immunity for administration of certain agreements between a hospital and the Division of Family and Children.

(Amended) *Medicaid Managed Care, Emergency Department Physician Services:* The bill requires an emergency department physician to notify a managed care organization after providing treatment to a recipient. It also requires a managed care organization to reimburse certain emergency department screening exams.

Anatomical Gifts Provisions: This bill requires a coroner to attempt to facilitate permission for transplantation of organs, tissues, and eyes. It establishes procedures that a pathologist must follow if the pathologist considers withholding organs or tissues. It requires the procurement organization to provide reimbursement for the cost of organ removal if the pathologist is required to be present to examine the decedent. The bill also provides that if a procurement organization has an agreement to perform anatomical gift services at a hospital the

procurement organization is considered the donee for gifts from patients who die at the hospital.

Effective Date: (Amended) July 1,2003 (Retroactive); December 30, 2004 (Retroactive); December 31, 2004 (Retroactive); Upon Passage; July 1, 2005.

Summary of State Impact: *Medicaid Managed Care, Lake County:* This provision is not expected to significantly impact expenditures in the Medicaid Program.

Medicaid Managed Care, Emergency Department Physician Services: The Office of Medicaid Policy and Planning reports that the state fiscal impact of this bill would be $1.4 M. The fiscal impact would not be realized by the state until January 2006, when risk-based managed care contracts are renewed. The fiscal impact of this provision will be dependent upon actions taken by the individual MCOs to control inappropriate use of emergency departments by their enrollees.

Hospital Care for the Indigent (HCI) Provisions: These provisions will mainly affect the calculation and the amount of property tax levies for the HCI Program.

Anatomical Gifts Provisions: These provisions will have no state fiscal impact. Local fiscal impact is addressed by allowing organ procurement organizations to reimburse certain coroner's costs.

Explanation of State Expenditures: *Medicaid Managed Care, Lake County:* This bill extends to December 31, 2007, certain provisions in current statute which affect the relationship between a Medicaid managed care organization (MCO) providing services in Lake County and the providers providing medical services to Medicaid recipients assigned to the MCO. The bill does specify the manner in which some reimbursement rates (between the MCO and the MCO's providers) are determined. The bill specifies that rates paid may not exceed the current Medicaid fee-for-service rates. Consequently, this provision is not expected to significantly impact expenditures in the Medicaid program.

The bill repeals two sections of the statute that expired on December 31, 2004.

(Revised) *Medicaid Managed Care, Emergency Department Physician Services:* This bill would require the Medicaid managed care organizations (MCOs) to pay 100% of the Medicaid fee-for-service reimbursement rates for certain federally required screening exams provided by a physician in an emergency room whether or not those services meet the definition of what a prudent layperson would consider to be an emergency unless the physician negotiates a different rate with the MCO. The bill would result in increased costs to the state to the extent that increased risk-based managed care costs would be passed through to the state in the negotiated capitated rates.

The Office of Medicaid Policy and Planning reports that the fiscal impact of this bill is estimated to be $3.7 M in total additional claims to the MCOs. The state impact would be $1.4 M. This estimate does not include any associated hospital outpatient claims which are not mentioned in the provisions of this bill. OMPP reports that within the PCCM program which is operated under the provisions of the similar existing statute, the physicians claims as well as the associated hospital emergency department claims are reimbursed. The fiscal impact of this provision will be dependent upon actions taken by the individual MCOs to control inappropriate use of emergency departments by their enrollees.

This bill provides for a physician payment issue regarding federally required emergency department screening

exams. Medicaid reports that the MCOs are required to pay for the screening exam performed on MCO recipients who present themselves at an emergency room. Physicians who are not contracted with the MCO, that is out-of-network providers, must be paid at 100% of the Medicaid fee-for-service reimbursement. The MCOs may deny payment for subsequent inappropriate use of ER services after a medical record review. At least one of the MCOs is reported to pay all of the physician claims for screening fees if the doctor is contracted with the MCO; ER physician claims from non-contracted providers are subject to review. This bill would require the payment for screening exams without authorization of the enrollee's primary medical provider. OMPP has estimated that the bill would require all the MCOs to pay for all screening or triage at 100% of the fee-for-service reimbursement for the physician and the hospital regardless of whether the patient believed there was an emergency condition or not. Financially, this requirement would impact the five MCOs differently depending on the contracted status of the emergency department physicians, if the organization is currently paying triage fees to contracted providers or denying the claims in total. Additionally, there has been no information provided with regard to how the associated hospital emergency department claims are handled by each of the MCOs. The fiscal impact of this provision will be dependent upon actions taken by the individual MCOs to control inappropriate use of emergency departments by their enrollees.

Medicaid managed care operates under a federally approved waiver. The regulation waived is the recipient's freedom of choice. MCO recipients select or are assigned a primary care provider to give the individual a "medical care home . The primary care provider is then responsible for that recipient's preventative and routine care. Controlling the cost of inappropriate use of emergency room services is one of the methods that MCOs use to control costs within the network.

In FY 2002 the MCOs reported 13,006 non-contracted physician emergency claims denied. Total denied payment at 100% of Medicaid fee-for-service rates was $576,666. Legislative mandates requiring the participation in Medicaid managed care for certain recipients residing in the state's largest counties were estimated to result in increases in denied claims and associated payments of $959,073 in FY 2004 and $996,865 in FY 2005 if the relationship between inappropriate emergency room usage per member per month remained stable. Managed care enrollment in the state expanded at a greater rate than initially projected in 2003. If MCO enrollment in January 2005 is applied to this same analysis, the FY 2005 estimate would be increased to $1.4 M in total cost or approximately $532,000 in state General Funds. This information is presented to reference the range of the prior estimated impact on physician costs only. The MCO contracts and their network provider contracts have changed as well as the inclusion of another MCO to the available risk-based managed care providers.

Any denied payments occur within the capitated managed care contracts. The denial of payment does not represent a direct savings or cost to the state since the state pays a capitated amount for each MCO member month regardless of the cost incurred by the MCO for the member's care. The bill would result in increased costs to the state to the extent that the increased risk-based managed care costs would be passed through to the state in the negotiated rates. Rate adjustments generally occur in January. Any fiscal impact related to this bill would not be anticipated to result in higher capitated rates until 2006.

Hospital Care for the Indigent (HCI) Provisions: This bill extends the period of time that a provider has to submit an application to the Division from 30 days from the patient encounter or admission to 45 days from the patient encounter or discharge. Effectively this provision allows physicians and transportation services an additional 15 days to submit an application for the HCI Program. Hospitals would have a time frame extended by 15 days plus the length of stay in the case of an admission. This provision has no fiscal impact.

The bill also provides that the Division may rely on information collected by the hospital in order to determine the individual's eligibility for the HCI Program. The bill also specifies that the expiration of the 45 days allowed for the Division to determine eligibility is not a valid reason to deny assistance for the HCI program. If the Division does not make a determination within the given time frame, the person is considered to be financially and medically eligible for the program. Depending on administrative actions taken by the Division of Family and Children to ensure that the county offices are familiar with the requirements of the HCI eligibility process, these provisions may increase the number of persons determined to be eligible for the HCI program. The program processed approximately 12,000 claims in FY 2004. Of these claims, about 8,500, or 71%, were over 91 days past the submission date when they were received by the central office. Additionally the agency reported that of the 12,000 claims submitted, about 5,600, o r 47%, were determined to be ineligible for the HCI program. The majority of these were determined to be financially ineligible. If under the provisions of this bill, these applications are considered to be eligible without regard for current financial or medical eligibility determinations, the level of claims assigned to the applicant's county of residence could grow significantly. County levy averages could be affected, although the impact would depend upon individual circumstances.

The bill would also allow the Division of Family and Children to contract with hospitals to determine financial and medical eligibility for the HCI program for the hospital's patients. The bill would further grant immunity to a hospital making the eligibility determination from civil and criminal liability that might arise from the implementation of this provision. Hospitals submit claims to the HCI program in order to calculate the county property tax levy amount as discussed in the *Explanation of Local Revenue* below. The hospital claims are not paid, rather the hospital receives a Medicaid add-on payment as a substitute. This allows the HCI funds to leverage federal funds within the Medicaid Program.

HCI Eligibility Determination Background: Prior to July 1, 2003, hospitals were not required to submit bills for the HCI program to the Division. The county Offices of Family and Children were required to determine eligibility only for the applicants for eligibility related to physician and transportation claims for payment. Effective July 1, 2003, applications for hospital claims were required to be submitted to the county DFC offices for eligibility determinations. Hospital claims will constitute the majority of the applications submitted for HCI program benefits. The Division may use HCI funds to reimburse the state administration account for the caseworker time involved in making the eligibility determination.

HCI Property Tax Levy: This provision would have no effect on the state's expense for PTRC and homestead credits.

Anatomical Gifts Provisions: This bill would add a procurement organization to the list of persons qualified to remove anatomical gifts. The bill also specifies that a procurement organization that has an agreement with a hospital to perform anatomical gift donation services for the hospital is considered to be the donee of all gifts from patients who have died at the hospitals except in the instance of a gift made by a donor for a specific donee.

The Centers for Medicare and Medicaid Services (CMS) requirements stipulate that patient deaths or imminent patient deaths be reported to the hospital's organ procurement organization (OPO) and that a request for an organ donation be made by the OPO requestor or another specially trained person. Joint Commission on Accreditation of Healthcare Organizations (JCAHO) requirements are similar and require hospitals to have a contract with an OPO to meet accreditation standards.

The bill specifies that if the pathologist considers withholding tissue of organs of a potential donor, the

pathologist shall be present during the removal of the organs or tissue. If the pathologist is required to be at the hospital to examine the decedent, before or during the removal of the organs, the procurement organization is required to reimburse the county or an entity designated by the county for actual costs not to exceed $1,000. (Coroners in rural areas may not have access to full-time pathologists who would be available to determine what tissue and organs may be harvested without destroying evidence needed for the coroner's investigation.)

Explanation of State Revenues: *Medicaid Managed Care Provisions:* See *Explanation of State Expenditures* regarding federal reimbursement in the Medicaid Program. Medicaid is a jointly funded state and federal program. Funding for direct services is reimbursed at approximately 62% by the federal government, while the state share is about 38%. Funding for administrative services is generally shared 50/50.

Hospital Care for the Indigent Provisions: The bill repeals provisions that allow the Division to pursue repayment of the amounts paid by the HCI Program from the applicants, their legally appointed representatives, or an estate. It also repeals the subrogation of patient's rights to potential insurance recoveries in the amount of the claims paid by the HCI Program. This provision will have a fiscal impact on the state dependent upon individual circumstances. The repeal of this provision will eliminate the Division's ability to seek recoveries from patients or their estates.

In the past, the Division has had collections from this source. Hospital claims are not paid through the HCI Program, and are currently not subject to recovery efforts by the Division. (Hospital claims are not paid through the HCI program; they are tracked in the program for property tax levy calculations only.) Physician and transportation claims are, however, paid through the HCI program. The amount of associated collections that would be lost as a result of the repeal would be dependent upon individual circumstances. Previous years' collections are shown below. Repayments and collections amounts shown below include amounts repaid by patients or their estates and Medicaid or insurance recoveries. Currently, recoveries and collections are not reflected as a deduction to the amounts reported to the counties for use in the levy calculations.

Fiscal Year	HCI Repayments & Collections	HCI Administrative Cost	Assistance Claims Paid
FY 2004	155,429	245,614	1,172,751
FY 2003	226,414	191,290	1,361,545
FY 2002	217,830	261,839	1,453,775
FY 2001	387,916	204,361	1,755,333
FY 2000	269,233	200,618	1,883,531

Explanation of Local Expenditures:

Explanation of Local Revenues: *HCI Property Tax Levy:* Under current law, the HCI tax levy in each county through CY 2006 is equal to the previous year's levy, multiplied by each county's actual 3-year assessed value growth quotient (AVGQ). The CY 2007 levy will equal the average annual amount of claims paid in the county in FY 2004, FY 2005, and FY 2006. Beginning in CY 2008, the levy will equal the average annual amount

of claims paid in the county in the three most recent completed fiscal years. However, the levies in CY 2007 and beyond are limited to the greater of (1) the CY 2006 levy or (2) the previous year's maximum levy multiplied by the county's actual 3-year AVGQ.

Under this proposal, the formula used in CY 2006 would be continued for CY 2007 and CY 2008. The levy formula that, under current law, will go into effect for CY 2007 levies would be delayed until CY 2009.

Under current law, the statewide total HCI levy is estimated at $51.1 M in CY 2005 and $51.5 M in CY 2006. Under the current levy formula, the levy cap is estimated at $56.0 M in CY 2007 and $61.8 M in CY 2008. The larger growth that begins in CY 2007 appears because of the annual assessed value adjustments that are currently scheduled to begin with assessments for taxes paid in CY 2006. These valuation adjustments directly affect the assessed value growth quotient used in the HCI levy formula.

The actual impact on CY 2007 and CY 2008 HCI levies is not known because the previous years' collections which are used in the levy formula are unknown at this time. However, since the CY 2007 and CY 2008 levies under the bill would be about the same as the levy cap under current law, the bill should not result in any increase in the HCI Fund levy.

State Agencies Affected: Office of Medicaid Policy and Planning, Family and Social Services Administration.

Local Agencies Affected: County coroners; County-owned hospitals.

Information Sources: Office of Medicaid Policy and Planning, Family and Social Services Administration; "Health Care at the Crossroads: Strategies for Narrowing the Organ Donation Gap and Protecting Patients , a policy paper of the Joint Commission On the Accreditation of Healthcare Organizations at: http://www.jcaho.org/about+us/public+policy+initiatives/organ+donation+white+paper ; and Gene Powlen, Cass County Coroner and President of the Indiana Coroner's Association, 574-722-5151.

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